2024-2025 PERMISSION FOR IN-SCHOOL SERVICES

Parent Name: _____ Student Name: _____

Therapy Group 1

THERAPY COMPANY _____

TYPE OF THERAPY _____

CASE MANAGER NAME _____

CASE MANAGER EMAIL _____

Therapy Group 2

THERAPY COMPANY _____

TYPE OF THERAPY _____

CASE MANAGER NAME _____

CASE MANAGER EMAIL _____

Therapy Group 3

THERAPY COMPANY _____

TYPE OF THERAPY _____

CASE MANAGER NAME _____

CASE MANAGER EMAIL _____

All providers are required to sign the Provider Policy agreement before entering Mainspring Academy's campus. I understand that any deviation from these expectations will be grounds for termination of the provider agreement. I understand that all providers visiting Mainspring must agree to these terms prior to providing services on campus.

I understand that it is my responsibility to initiate communication between the clinician and School Administration, via email, at the initiation of the school year and/or start of services. Any changes in provider information should be communicated by the parent to School Administration.

Parent Signature_____Date_____